

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>51553</p> <p>Based on observation, record review and staff interview, the facility failed to provide care in a manner and environment that promoted a dignified dining experience for the residents. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #61, #50, #22, #57, #1, #2, #29. Facility Census: 65.</p> <p>Findings included:</p> <p>a) On 03/31/25 at 12:55 PM, during the dining observation, resident's were not seated at the same time at tables, the lunch meal did not arrive at the same time for resident's at the same table, six (6) residents were left seated in the center of the dining room while the other resident's were at their tables and served beverages and lunch meals and clothing protectors were placed on residents without asking their preference.</p> <p>At 1:05 PM, Resident #61 tried multiple times to feed Resident #50 from their tray. The state surveyor intervened for staff to re-direct the resident. Resident #50 received the lunch tray at 1:13 PM. Resident #1 was fed at 01:32 PM after the tablemate's lunch had been fed beginning at 1:12 PM. Staff began feeding Resident #2 at 1:16 PM at the same table as Resident #29. Resident #29 was continuously reaching for her tray on table which was moved out of reach by staff. Resident #29 was fed her lunch tray in the dining room after 1:45 PM. Resident's #29's food was on the table the whole time. The facility's policy and procedure stated, Meals are served table by table.</p> <p>45173</p> <p>b) Resident #22</p> <p>On 03/31/25 at 12:38 PM, the lunch trays arrived at the dining room on A hall. Resident #22 was sitting with another resident. Nurse Aide (NA) #66 sat Resident #22's food in front of her. The resident was sitting in a geri-chair with a clothing protector on, which was covering up her hands. The resident was tearful throughout the entire experience.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/31/25 at 12:49 PM, Licensed Practical Nurse (LPN) # 78 began feeding the Resident #22. The resident waited 11 minutes before a staff member started assisting the resident with lunch. LPN #78 was standing while assisting Resident #22. On 03/31/25 at approximately 1:05 PM, LPN #78 was interviewed regarding standing while feeding the resident and the resident's wait time for meal assistance. LPN #78 stated, I didn't know.</p> <p>On 04/01/25 at 9:05 AM, the Director of Nursing (DON) was notified of the issue regarding the dignity of the resident during meal time. The DON stated, I will give the nurse education.</p> <p>c) Resident #57</p> <p>On 03/31/25 at 12:38 PM, the lunch trays arrived at the dining room on A hall. Resident #57 was seated with two (2) other residents at the table. The resident did not receive his food until 12:43 PM, which was five (5) minutes, while the other residents were eating their meals.</p> <p>On 04/01/25 at 9:05 AM, the DON was notified. The DON stated, We are working on meals .Dietary does not put the trays in the cart by rooms. They are loading them on the cart randomly.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>51553</p> <p>Based on observation, record review and staff and resident interview, the facility failed to ensure a resident with limited Range of Motion (ROM) was able to reach the call light to call for assistance. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifier: #38. Facility Census: 65</p> <p>Findings included:</p> <p>a) Resident #38</p> <p>During the initial interview process, Resident #38 was observed sitting upright in bed and leaning toward the left. The resident attempted to position himself, but was unable. The patient attempted to use the call light, but was unable to reach it. The patient has a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. The state surveyor pushed the call light for the resident at the resident's request. Nurse Aide (NA) #36 answered the call light promptly and asked the Director of Nursing (DON) for assistance with repositioning the resident.</p> <p>b) NA #36 reported the patient will use his call light and stated, When he has it, he usually does. The DON reported the resident used to have a pancake call light. The DON instructed NA #36 to place the resident's call light on the right side of the bed in reach for the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to complete a change in condition (CIC) for Resident #22's development of a pressure ulcer on the right heel. This was a random opportunity for discovery. Resident Identifier: #22. Facility Census: 65.</p> <p>Findings Include:</p> <p>a) Resident #22</p> <p>On 03/31/25 at 2:30 PM, a progress note was reviewed. The progress note dated 03/31/25 at 1:16 PM stated, Resident has a blister to her right heel. NP (Nurse Practitioner) in facility this morning and visited resident. New order for Sure Prep to right heel BID (twice daily). POA (Power of Attorney) notified and in agreement with order. (Typed as written.) Upon further review, no change in condition was found for Resident #22.</p> <p>On 04/01/25 at 2:00 PM, an interview was held with the Director of Nursing (DON). The DON confirmed the resident did have a blister to the right heel and no change in condition had been completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51553</p> <p>Based on observation and record review, the facility failed to provide a home-like environment during the dining experience. This failed practice had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 65.</p> <p>Findings included:</p> <p>a)The facility's policy and procedure stated, All items are removed from trays and are appropriately placed in front of the resident, packages are opened, and lids are removed.</p> <p>b) On 03/31/25 at 12:55 PM during the facility's dining observation, the staff left a resident's food on their tray when during the lunch meal. An additional resident's tray was left on the table beside the resident's meal while they ate lunch.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45173</p> <p>Ensure each resident receives an accurate assessment.</p> <p>Based on record review and staff interview, the facility failed to ensure an accurate Minimum Data Set (MDS) regarding weight loss. This was true for one (1) of two (2) residents reviewed under the care area of tube feeding. Resident Identifier: #61. Facility Census: 65.</p> <p>Findings Include:</p> <p>a) Resident #61</p> <p>On 03/31/25 at 4:51 PM, a record review identified the resident was noted with significant weight loss. The resident's weight on 02/05/25 was 176.8 pounds. The resident's weight on 03/07/25 was 167.2 pounds. This is a significant weight loss of -5.43% in 30 days.</p> <p>A review of the MDS significant change dated 03/10/25 section K regarding weight loss was reviewed on 03/31/25 at 7:00 PM. The MDS stated no or unknown for the question K0300 for loss of 5% or more in the last month or loss of 10% or more in 6 months.</p> <p>On 04/02/25 at 3:40 PM, the Director of Nursing (DON) confirmed the MDS was incorrect regarding significant weight loss.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on observation, record review, and staff interview, the facility failed to implement or develop comprehensive, person-centered care plans for four (4) of 22 residents. Resident #22's care plan was not implemented regarding a dietary restriction, documenting meal intakes, and for the risk of limited engagement. Resident #31's care plan was not implemented for monitoring of medication side effects and behaviors, pain assessments, and anticoagulation monitoring. The facility failed to develop a care plan for Resident #57 and #59 to include all diagnoses. Resident Identifiers: #22, #31, #57, #59, #25. and #51. Facility Census: 65.</p> <p>Findings included:</p> <p>a) Resident #22</p> <p>On 03/31/25 at 12:38 PM, the lunch trays arrived at the dining room on A hall. Resident #22 was sitting with another resident. Nurse Aide (NA) #66 sat Resident #22's food in front of her. The resident was sitting in a geri-chair with a clothing protector on, which was covering up her hands. The resident was tearful throughout the entire dining experience. On 03/31/25 at 12:49 PM, Licensed Practical Nurse (LPN) # 78 began feeding the Resident #22. The resident waited 11 minutes before a staff member started assisting her with lunch. LPN #78 was standing while assisting Resident #22 and feed the resident pork, which was listed as a dietary restriction. On 03/31/25 at approximately 1:05 PM, LPN #78 was interviewed regarding the dietary restriction. LPN #78 stated, I didn't know. NA #66 stated, I think its a religious thing NA #66 then stated, I served her the food .I didn't realize it was pork .I laid the lunch ticket over here (on counter behind the resident) . After reviewing the lunch ticket, No Pork is typed on the lunch ticket twice.</p> <p>On 04/01/25 at 9:05 AM, the Director of Nursing (DON) was notified of the issue regarding the dietary restriction for the resident. The DON stated, it is not a religious restriction .I think she just didn't eat pork .I agree the care plan under the focus area of nutritional risk was not implemented due to the intervention listed no pork diet as ordered.</p> <p>On 04/01/25 at 11:10 AM, a telephone interview was held with the Medical Power of Attorney (MPOA). The MPOA was asked, is the dietary restriction for pork due to a religious reason? The MPOA stated, no .she was raised to not eat pork .my grandmother never ate pork</p> <p>On 04/01/25 at 11:30 AM, the care plan intervention under the focus area of nutrition risk was not implemented regarding monitor intake at all meals, offer alternate choices if needed, alert dietician and physician to any decline in intake. On 04/02/25 at 11:00 AM, a further review of the meal intake for the last 30 days from 03/04/25 through 04/01/25 was completed. The review found missing documentation for meal intake for the following days:</p> <p>--03/09/25 missing documentation for one (1) meal</p> <p>--03/14/25 missing documentation for one (1) meal</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--03/19/25 missing documentation for one (1) meal</p> <p>--03/23/25 missing documentation for one (1) meal</p> <p>--03/30/25 missing documentation for one (1) meal</p> <p>On 04/02/25 at 12:19 PM, the DON confirmed the meal intakes were not documented; and, the care plan was not implemented.</p> <p>On 03/31/25 at 12:38 PM, the resident was observed in the dining room. The resident was sitting in a geri-chair with a clothes protector on, covering her hands. The resident was tearful throughout the entire dining experience.</p> <p>On 03/31/25 at 3:15 PM, the resident was observed sitting in a geri-chair. The resident was sitting in a corner, tearful for approximately 20 minutes before a staff member approached her.</p> <p>A review of the care plan on 04/01/25 at 11:30 AM, under the focus area of risk for limited engagement found two (2) interventions in regards to the resident being tearful. The first intervention states, observe for signs and symptoms for tearfulness .offer her Hug'able doll to her and if necessary gently guide her to a calm private location. The second intervention listed is as follows: (Resident name) enjoys watching the (name of program) channel in her room. If you notice signs of tearfulness, .offer to put on the (name of program) channel for her. Quiet time in her room while watching her favorite channel helps to calm her down and comfort her.</p> <p>On 04/02/25 at 12:30 PM, the Director of the Memory Unit (DOMU), confirmed the care plan interventions were not implemented. The DOMU then stated, Sometimes other residents don't want the channel changed . I agree there was no huggable doll around and she could be taken to her room to turn on (name of program).</p> <p>On 04/02/25 at 12:49 PM, the DON confirmed the care plan had not been implemented when the resident became tearful.</p> <p>b) Resident #31</p> <p>On 04/01/25 at 9:14 PM, a record review for unnecessary medications was completed for Resident #31. The review found the care plan interventions were not being implemented regarding the monitoring of medication side effects and behaviors, pain assessments, and anticoagulation monitoring for 01/2025 and 02/2025.</p> <p>The care plan intervention under the focus area of exhibits or has the potential for .behaviors is monitor medications especially new/changed/discontinued, for side effects and resident's/patient's response to contributing to verbal behaviors. The following dates on the Medication Administration Record (MAR) with no documentation are as follows:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--01/14/25 day shift</p> <p>--01/15/25 day shift</p> <p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>The care plan intervention under the focus area of resistive to care is observe for pain. Attempt non-pharmacologic interventions to alleviate pain. The following dates on the MAR with no documentation are as follows:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/25 day shift</p> <p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>The care plan intervention under the focus area of risk for injury or complications related to the use of antiplatelet and anticoagulant therapy, observe for active bleeding, (i.e. hematuria, bruising, guaiac + stool, nose bleeds, bleeding gums, etc. The following dates on the MAR with no documentation are as follows:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/25 day shift</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>On 04/02/25 at 11:15 AM, the DON confirmed the care plan had not been implemented in these care areas.</p> <p>c) Resident #57</p> <p>On 04/01/25 at 10:31 AM, a record review was completed for Resident #57. The review found the care plan had not been developed to include all diagnoses. The following diagnoses were not included:</p> <p>--unspecified protein-calorie malnutrition</p> <p>--dysphagia, unspecified</p> <p>On 04/02/25 at 11:15 AM, the DON confirmed the diagnoses were not developed in the care plan.</p> <p>d) Resident #59</p> <p>On 04/01/25 at 3:00 PM, a record review was completed for Resident #59. The review found the care plan had not been developed to include all diagnoses. The following diagnoses were not included:</p> <p>--hypertension</p> <p>--hyperlipidemia</p> <p>--osteoporosis</p> <p>--anemia</p> <p>--muscle weakness</p> <p>--muscle spasms</p> <p>On 04/02/25 at 11:15 AM, the DON confirmed the diagnoses were not developed in the care plan.</p> <p>e) Resident # 25</p> <p>On 04/03/25 at 9:52 AM a review of the medical record for Resident #25 who was admitted on [DATE] with diagnoses of schizoaffective disorder, depressive type, anxiety disorder, major depressive disorder, vascular dementia with agitation, psychotic disorder, seizures and mood disturbance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08//28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25/21/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/08/25 for night shift</p> <p>03/12/25 for day shift</p> <p>03/15/25 for night shift</p> <p>03/17/25 for day shift</p> <p>In an interview on 04/03/25 at 8:40 AM with the Administrator, he concurred there were issues with documentation and care plans.</p> <p>f) Resident #51</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/25 at 9:52 AM a review of the medical record for Resident #51 who was admitted on [DATE] with diagnoses of depression, Alzheimer's, dementia with behavioral disorder and wandering.</p> <p>f) Resident #51</p> <p>On 04/03/25 at 9:52 AM a review of the medical record for Resident #51 who was admitted on [DATE] with diagnoses of depression, Alzheimer's, dementia with behavioral disorder and wandering.</p> <p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08//28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/09/25 for night shift</p> <p>03/12/25 for day shift</p> <p>03/15/25 for night shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/17/25 for day shift</p> <p>In an interview on 04/03/25 at 8:40 AM with the Administrator, he concurred there were issues with documentation and care plans.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153</p> <p>Based on record review and staff interview, the facility failed to ensure care plans were revised for Residents #42 fall, #22 dependent for meals, #57 independent for mobility, #4 full code, #23 give fluids when NPO, and #28 hospice when not ordered. These failed practices affected more than a limited number of residents. Resident identifiers: #42, #22, #57, #4, #23, and #28. Facility census: 65.</p> <p>Findings included:</p> <p>a) Resident #42</p> <p>On [DATE] at approximately 11:00 AM, a record review was completed for Resident #42. The review found the resident had a fall on [DATE]. An x-ray was completed with no abnormalities found. However, the resident continued to complain with pain upon movement. A computed tomography scan (CT) was ordered by the facility physician on [DATE]. The CT results were received on [DATE], with the following finding: There are fractures of the left superior and inferior rami, there is also a fracture through the left side of the sacrum.</p> <p>The care plan was reviewed on [DATE] at 11:15 AM. The care plan had not been revised indicating the resident had a fall with injury. The care plan focus area states, Resident is at risk for falls .</p> <p>On [DATE] at 12:19 PM, the Director of Nursing (DON) confirmed the care plan had not revised to indicate the resident had an actual fall with major injury.</p> <p>b) Resident #22</p> <p>On [DATE] at 11:30 AM, a record review was completed for Resident #22. The care plan under the focus area of Resident requires assistance with activities of daily living (ADL) states the resident is set up assist with eating. However, on [DATE] at 12:38 PM, an observation of the resident being feed per staff was made.</p> <p>On [DATE] at 12:19 PM, the DON confirmed the care plan had not been revised to indicate the resident is dependent at times for meals.</p> <p>c) Resident #57</p> <p>On [DATE] at 10:31 AM, a record review was completed for Resident #57. The care plan was reviewed and found an intervention of provide resident/patient with supervision ambulating using a walker. However, throughout the survey, from [DATE] through [DATE], no observations of the resident using a walker were made. The resident does walk with a bended at waist gait. This type of gait is due to the resident's diagnosis of Parkinson's disease.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 1:11 PM, the DON was interviewed regarding Resident #57's ability to ambulate. The DON stated, when he first came here he used a walker, but now with the dementia he doesn't know what to do with a walker. The DON confirmed the resident ambulated independently and the care plan had not been revised.</p> <p>d) Resident #4</p> <p>The facility failed to revise Resident #4's care plan for a change in Code status. On [DATE] at 8:52 AM, the resident's order stated, No CPR- Do not attempt Resuscitation. Comfort focused treatment. Maximize comfort through symptom management, allowing natural death. Use oxygen suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or selective treatment unless consistent with comfort goals. Transfer to hospital only if comfort cannot be achieved in the current setting. No artificial means of nutrition. No directions specified for order. The</p> <p>Resident #4's care plan stated, the resident has an established advanced directive of FULL CODE Full Code- Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatment as indicated to attempt to prolong life, including intensive care. On [DATE] at 04:12 PM, the resident's updated POST form, dated and signed [DATE], was obtained. The POST form was marked, No CPR: Do Not Attempt Resuscitation and Comfort -focused Treatments. The DON confirmed the resident's care plan stated the resident's advanced directive was for a full code.</p> <p>e) Resident #23</p> <p>The facility failed to revise Resident #23's care plan to reflect a change in advance directives for an alternate means of nutrition and encourage fluids with meals for an NPO (nothing by mouth) resident. On [DATE] at 2:22 PM, the resident's physician order stated, Full Code- Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatment as indicated to attempt to prolong life including intensive care. No artificial means of nutrition desired. No directions specified for order.</p> <p>The resident's current care plan stated, Resident #23 has a HCS and Full Code- Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatment as indicated to attempt to prolong life including intensive care. No artificial means of nutrition desired. The resident's orders stated NPO with Enternal Feed. On [DATE] at 04:10 PM, the Director of Nursing confirmed the resident's care plan stated, No artificial means of nutrition desired. On [DATE] at 8:45 AM, the DON confirmed, Resident #23's care plan stated Encourage resident to consume all fluids of choice during meals. Resident's current diet order stated, NPO (nothing by mouth) diet.</p> <p>f) Resident #38</p> <p>The facility failed to revise Resident #38's care plan who is not receiving hospice services. No order was found on the resident's medical chart for hospice services. The resident's care plan stated, Notify Hospice of yet another fall with minor injury to gain (name of hospice) input for plan of care (POC) intervention., (Name of hospice) to provide resident with a wheelchair with cushion to help enhance independence. and Resident will achieve acceptable level of pain control, as defined by the patient through his hospice care. On [DATE] at 10:15 AM, the DON confirmed, the resident's care plan stated the resident was receiving Hospice Services. No resident in the facility was receiving hospice services at this time per report.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45173 51553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on record review and staff interview, the facility failed to ensure physician orders were followed. medications were administered timely, behaviors, and pain were monitored. This had the potential to affect more than a limited number of residents. Resident identifiers: #31, #22, #59, #57, #25, #51 and facility late medications, #28, #49, #37, #23, #36, #8, #7, #41, #50, #9, #41, #50, #20, #63, #42, #58, #61, #23, #10, #15, #17, #267, and #268. Facility census: 65.</p> <p>Findings included:</p> <p>a) Resident #31</p> <p>On 04/01/25 at 9:30 AM, a record review was completed for Resident #31. The review found the physician's orders were not being followed on the 01/2025 and 02/2025 medication administration records (MARs). The following physician's orders and dates are as follows:</p> <p>--Anticoagulant Medication Monitoring:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/24 day shift</p> <p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>--Monitor for Behaviors:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/24 day shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --Ask resident if they are having pain: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --Monitor swallowing during med pass: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--02/12/25 day shift</p> <p>--Antiembolism monitoring:</p> <p>--02/11/25</p> <p>--02/12/25</p> <p>On 04/01/25 at 12:19 PM, the Director of Nursing (DON) confirmed the physician's orders were not followed.</p> <p>b) Resident #22</p> <p>On 03/31/25 at 12:38 PM, an observation was made of the resident being fed pork at lunch time. On 03/31/25 at 2:00 PM, the physician's orders were reviewed for Resident #22. The review found a physician's order for regular, dysphagia advanced texture, standard thin liquids consistency, no pork or pork products. Send finger foods when possible.</p> <p>On 04/01/25 at 11:30 AM, the DON confirmed the physician's order was not followed regarding the dietary restriction of no pork.</p> <p>c) Resident #59</p> <p>On 04/01/25 at 10:00 AM, a record review was completed for Resident #59. The review found the physician's orders were not being followed on the MARs for 01/2025, 02/2025 and 03/2025. The following physician's orders and dates are as follows:</p> <p>--Ask resident if they are having pain:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/24 day shift</p> <p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>--03/08/25 night shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Is resident free from adverse/side effects of antidepressant medication: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Is resident free from adverse/side effects of antipsychotic: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Monitor for behaviors: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Monitor swallowing during med pass: --01/09/25 day shift --01/13/25 day shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Is resident free from adverse/side effects of antimanic/antiseizure medication: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--03/17/25 day shift</p> <p>On 04/01/25 at 12:19 PM, the Director of Nursing (DON) confirmed the physician's orders were not followed.</p> <p>d) Resident #57</p> <p>On 04/01/25 at 10:00 AM, a record review was completed for Resident #57. The review found the physician's orders were not being followed on the MARs for 01/2025, 02/2025 and 03/2025. The following physician's orders and dates are as follows:</p> <p>--Ask resident if they are having pain:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/24 day shift</p> <p>--01/16/25 day shift</p> <p>--01/17/25 night shift</p> <p>--01/28/25 day shift</p> <p>--02/11/25 day shift</p> <p>--02/12/25 day shift</p> <p>--03/08/25 night shift</p> <p>--03/12/25 day shift</p> <p>--03/15/25 night shift</p> <p>--03/17/25 day shift</p> <p>--Monitor for behaviors:</p> <p>--01/09/25 day shift</p> <p>--01/13/25 day shift</p> <p>--01/14/25 day shift</p> <p>--01/15/24 day shift</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Monitor swallowing during med pass: --01/09/25 day shift --01/13/25 day shift --01/14/25 day shift --01/15/24 day shift --01/16/25 day shift --01/17/25 night shift --01/28/25 day shift --02/11/25 day shift --02/12/25 day shift --03/08/25 night shift --03/12/25 day shift --03/15/25 night shift --03/17/25 day shift --Ketoconazole Shampoo 2% apply to scalp topically every day shift Monday, Wednesday, Saturday for tinea versicolor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--01/23/25</p> <p>--03/12/25</p> <p>On 04/01/25 at 12:19 PM, the Director of Nursing (DON) confirmed the physician's orders were not followed.</p> <p>e) Resident # 25</p> <p>On 04/03/25 at 9:52 AM a review of the medical record for Resident #25 who was admitted on [DATE] with diagnoses of schizoaffective disorder, depressive type, anxiety disorder, major depressive disorder, vascular dementia with agitation, psychotic disorder, seizures and mood disturbance.</p> <p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08/28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25/21/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/08/25 for night shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/12/25 for day shift</p> <p>03/15/25 for night shift</p> <p>03/17/25 for day shift</p> <p>f) Resident #51</p> <p>On 04/03/25 at 9:58 AM a review of the medical record for Resident #51 who was admitted on [DATE] with diagnoses of depression, Alzheimer's, dementia with behavioral disorder and wandering.</p> <p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08//28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/09/25 for night shift</p> <p>03/12/25 for day shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/15/25 for night shift</p> <p>03/17/25 for day shift</p> <p>g) Facility</p> <p>On 04/03/25 at 11:30 AM, the daily staff postings were reviewed for 03/29/25 and 03/30/25. The review found only two (2) nurses scheduled for both dates; one (1) on the red hall and one (1) on the blue hall. The red hall has 26 beds and the blue hall had a census of 42 residents who reside on the blue hall. No other nurse was scheduled on the blue hall during day shift. The nurse schedule provided had noted a need for day shift on 03/29/25 and 03/30/25. The daily nursing hours per patient day was above the minimum; but, multiple medications were late and multiple treatment orders were incomplete. The acuity of the residents was higher on these day with only one (1) nurse on the blue hall.</p> <p>The following list of late medications for each resident is as follows:</p> <p>Resident #28</p> <p>-03/29/25 Neurontin 300mg (milligram) by mouth three times daily--ordered for 2:00 PM; given at 3:42 PM. This was one hour and 42 minutes late.</p> <p>-03/29/25 Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3ml (milliliters) inhale orally three times daily--ordered for 2:00 PM; given at 3:42 PM. This was one hour and 42 minutes late.</p> <p>Resident #62</p> <p>-03/30/25 Midodrine 10mg by mouth three times daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Zinc 50mg by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Glimepiride 1mg by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Diltiazem 90mg give 2 capsules by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>Resident #49</p> <p>-03/30/25 Losartan Potassium 100mg by mouth daily--ordered for 10:00 AM; given at 11:40 AM. This is one hour and 40 minutes late.</p> <p>-03/30/25 Metoprolol Succinate 100mg by mouth daily--ordered for 10:00 AM; given at 11:40 AM. This is one hour and 40 minutes late. I</p> <p>--03/30/25 Farxiga 10mg by mouth daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Spironolactone 25mg by mouth daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>-03/30/25 Apixaban 5mg by mouth two times daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>-03/30/25 Divalproex 500mg by mouth two times daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>Resident #37</p> <p>-03/30/25 Duloxetine 20mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Farxiga 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>-03/30/25 Amlodipine Besylate 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>-03/30/25 Folic Acid 1mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>-03/30/25 Quetiapine Fumarate 25mg 1/2 tablet by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Magnesium Oxide 400mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>-03/30/25 Potassium Chloride 10meq (milliequivalent) by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Lisinopril 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>-03/30/25 Senna 8.6mg by mouth twice daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Thiamine 100mg by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Metoprolol Tartrate 50mg by mouth twice daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Basaglar 75 units subcutaneous daily--ordered for 8:00 AM; given at 9:56 AM. This is one hour and 56 minutes late.</p> <p>Resident #23</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/29/25 Enteral feed Jevity 1.5 calories 474 ml three times daily--ordered for 5:00 PM; given at 7:10 PM. This is 2 hours and 10 minutes late.</p> <p>Resident #36</p> <p>-Tylenol Extra Strength 500mg give 2 tablets by mouth twice daily--ordered for 10:00 AM; given at 11:47 AM. This is one hour and 47 minutes late.</p> <p>-Glycolax Powder give 17 grams by mouth daily--ordered for 10:00 AM; given at 11:47 AM. This is one hour and 47 minutes late.</p> <p>Resident #8</p> <p>-Protonix 40mg by mouth twice daily--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>-Escitalopram 5mg by mouth daily--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>-Tylenol Extra Strength 500mg by mouth three times a day--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>Resident #7</p> <p>-03/29/25 Sertraline 25mg by mouth daily--ordered for 9:00 AM; given at 10:57 AM. This is one hour and 57 minutes late.</p> <p>Resident #41</p> <p>-03/30/25 Cymbalta 20mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Zinc 220mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Colace 100mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Metformin 1000mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Protonix 40mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Synthroid 100mcg (microgram) by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Farxiga 10mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Eliquis 5mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Sitagliptin 25mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Furosemide 40mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Digoxin 125mcg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>Resident #50</p> <p>-03/29/25 Tylenol Extra Strength 500mg give 2 tablets twice daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Protonix 40mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Aspirin 81mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Omeprazole 20mg twice daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Buspar 10mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>The following physician's orders for resident treatments were not followed:</p> <p>Resident #9</p> <p>-03/29/25 apply antifungal to bilateral groin areas twice daily--no documentation for day shift</p> <p>-03/30/25 apply antifungal to bilateral groin areas twice daily--no documentation for day shift</p> <p>--03/29/25 cleanse MASD to left buttock with no-rinse foaming wash and pat dry. Apply calazime cream to open areas only. Apply hydroguard to surrounding skin every day and night shift --no documentation for day shift</p> <p>--03/30/25 cleanse MASD to left buttock with no-rinse foaming wash and pat dry. Apply calazime cream to open areas only. Apply hydroguard to surrounding skin every day and night shift --no documentation for day shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #41</p> <p>-03/29/25 Eye scrubs: mix baby shampoo with warm water, gently wipe each eye separately, rinse with warm water and pat dry, using clean technique every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Eye scrubs: mix baby shampoo with warm water, gently wipe each eye separately, rinse with warm water and pat dry, using clean technique every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Cleanse ulcer to right lower extremity with normal saline, pat dry, apply collagen particles, cover with hydrogel impregnated gauze, wrap with kerlix, and secure with ace wrap every Tuesday, Thursday and Saturday--no documentation for day shift.</p> <p>Resident #50</p> <p>-03/29/25 Cleanse bilateral buttocks and scrotum with warm water and mild soap, rinse and dry completely. Apply barrier cream after episodes of incontinence--no documentation for day shift.</p> <p>-03/30/25 Cleanse bilateral buttocks and scrotum with warm water and mild soap, rinse and dry completely. Apply barrier cream after episodes of incontinence--no documentation for day shift.</p> <p>-03/29/25 Hydrocortisone External Cream 2.5% Apply to face, back and thighs every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Hydrocortisone External Cream 2.5% Apply to face, back and thighs every day and night shift--no documentation for day shift.</p> <p>Resident #20</p> <p>-03/29/25 Apply Ammonium Lactate External cream to bilateral lower legs every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Apply Ammonium Lactate External cream to bilateral lower legs every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Silver Sulfadiazine cream 1% apply to bilateral groin and buttocks every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Silver Sulfadiazine cream 1% apply to bilateral groin and buttocks every day and night shift--no documentation for day shift.</p> <p>Resident #63</p> <p>-03/29/25 Apply barrier cream to MASD to sacrum every day and night shift--no documentation for day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Apply barrier cream to MASD to sacrum every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Cleanse surgical incision to right shoulder with wound cleanser, pat dry, cover with dry dressing every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Cleanse surgical incision to right shoulder with wound cleanser, pat dry, cover with dry dressing every day and night shift--no documentation for day shift.</p> <p>Resident #42</p> <p>-03/29/25 Cleanse right heel DTI with normal saline, pat dry, apply betadine to area and cover with foam dressing. Secure with kerlix and tape every Tuesday, Thursday and Saturday--no documentation for day shift.</p> <p>Resident #58</p> <p>-03/29/25 Apply kerlix and coban starting behind the toes up to below the knee on bilateral lower extremities every 3 days per Vascular Surgery--no documentation for day shift.</p> <p>Resident #61</p> <p>-03/29/25 Enteral Feed: Cleanse site daily with soap and water every day shift--no documentation for day shift.</p> <p>-03/30/25 Enteral Feed: Cleanse site daily with soap and water every day shift--no documentation for day shift.</p> <p>-03/29/25 Monitor surgical incision to right rear head for possible signs/symptoms of infection every day and night shift-no documentation for day shift.</p> <p>-03/30/25 Monitor surgical incision to right rear head for possible signs/symptoms of infection every day and night shift-no documentation for day shift.</p> <p>Resident #23</p> <p>-03/29/25 Cleanse PEG site with normal saline moistened gauze and pat dry, apply bacitracin and a split gauze and secure with tape every day shift--no documentation for day shift.</p> <p>-03/30/25 Cleanse PEG site with normal saline moistened gauze and pat dry, apply bacitracin and a split gauze and secure with tape every day shift--no documentation for day shift.</p> <p>Resident #10</p> <p>-03/29/25 Acetic Acid Irrigation Solution 0.25% use 30 cc (cubic centimeters) via irrigation every day and night shift for occlusion--no documentation for day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Acetic Acid Irrigation Solution 0.25% use 30 cc (cubic centimeters) via irrigation every day and night shift for occlusion--no documentation for day shift.</p> <p>-03/29/25 Apply z-guard to buttocks every day and night shift for MASD--no documentation for day shift.</p> <p>-03/30/25 Apply z-guard to buttocks every day and night shift for MASD--no documentation for day shift.</p> <p>Resident #15</p> <p>-03/29/25 Apply skin prep daily to arterial ulcers to 1st, 2nd and 3rd digits. Notify provider if any signs/symptoms of infection every day shift--no documentation for day shift.</p> <p>-03/30/25 Apply skin prep daily to arterial ulcers to 1st, 2nd and 3rd digits. Notify provider if any signs/symptoms of infection every day shift--no documentation for day shift.</p> <p>Resident #17</p> <p>-03/29/25 Monitor left foot for any skin changes related to incident where foot was ran over with a wheel chair x one week. Notify physician if any changes occur every day shift--no documentation for day shift.</p> <p>-03/30/25 Monitor left foot for any skin changes related to incident where foot was ran over with a wheel chair x one week. Notify physician if any changes occur every day shift--no documentation for day shift.</p> <p>--Resident #267</p> <p>-03/29/25 Apply skin prep outer great left toe every day shift DTI--no documentation for day shift.</p> <p>-03/30/25 Apply skin prep outer great left toe every day shift DTI--no documentation for day shift.</p> <p>Resident #268</p> <p>-03/29/25 Monitor surgical incision to left hip, Report any signs/symptoms of infection to provider. Cleanse area with wound cleanser, Pat dry. May leave open to air if no drainage every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Monitor surgical incision to left hip, Report any signs/symptoms of infection to provider. Cleanse area with wound cleanser, Pat dry. May leave open to air if no drainage every day and night shift--no documentation for day shift.</p> <p>30153</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to prevent the development of an avoidable pressure ulcer to the right heel for Resident #22. This was true for one (1) of three (3) records reviewed under the care area of pressure ulcers. Resident Identifier: #22. Facility Census: 65.</p> <p>Findings include:</p> <p>a) Resident #22</p> <p>On 04/01/25 at 11:30 AM, a record review was completed for Resident #22. A progress note dated 03/31/25 at 1:41 PM stated, Note: Resident has a blister to her right heel. NP (Nurse Practitioner) in facility this morning and visited resident. New order for Sure Prep to right heel BID (twice daily). POA (Power of Attorney) notified and in agreement with order.</p> <p>On 04/01/25 at 12:19 PM, the Director of Nursing confirmed the resident had developed a pressure ulcer on her right heel.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45173</p> <p>Based on observation, record review, and staff interview, the facility failed to transfer oxygen tanks in a safe manner. This was a random opportunity for discovery. Facility Census: 65.</p> <p>Findings Include:</p> <p>a) Oxygen tanks</p> <p>On 04/03/25 at 12:32 PM, an observation of the Maintenance Director carrying four (4) oxygen tanks, with no carrier used. The Maintenance Director had two (2) oxygen tanks in each hand, as he walked around the building the tanks were clanking together.</p> <p>On 04/03/25 at 12:34 PM, an interview was held with the Maintenance Director. the Maintenance Director stated, I know I'm not supposed to carry them this way .I'm trying to help her (referring to the oxygen delivery person) and she is tired.</p> <p>On 04/03/25 at 12:48 PM, the Corporate RN was notified. The Corporate RN shook her head in agreement and confirmed the oxygen tanks should not be transported without a carrier.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173</p> <p>Based on record review and staff interview, the facility failed to have sufficient staffing for the B hall on 03/29/25 and 03/30/25. This failure has the potential to affect more than a limited number of residents. Facility Census: 65.</p> <p>Findings Include:</p> <p>a) B hall residents</p> <p>On 04/03/25 at 11:30 AM, the daily staff postings were reviewed for 03/29/25 and 03/30/25. The review found only two (2) nurses scheduled for both dates; one (1) on the red hall and one (1) on the blue hall. The red hall has 26 beds and the blue hall had a census of 42 residents. No other nurse was scheduled on the blue hall during day shift. The nurse schedule provided had noted a need for day shift on 03/29/25 and 03/30/25. The daily nursing hours per patient day were above the minimum; but, multiple medications were late and multiple treatment orders were incomplete. The acuity of the residents was higher on these days with only one (1) nurse on the blue hall.</p> <p>The following list of late medications for each resident is as follows:</p> <p>--Resident #28</p> <p>-03/29/25 Neurontin 300mg (milligram) by mouth three times daily--ordered for 2:00 PM; given at 3:42 PM. This was one hour and 42 minutes late.</p> <p>-03/29/25 Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3ml (milliliters) inhale orally three times daily--ordered for 2:00 PM; given at 3:42 PM. This was one hour and 42 minutes late.</p> <p>--Resident #62</p> <p>-03/30/25 Midodrine 10mg by mouth three times daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Zinc 50mg by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Glimepiride 1mg by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>-03/30/25 Diltiazem 90mg give 2 capsules by mouth daily--ordered for 9:00 AM; given at 11:32 AM. This is two hours and 32 minutes late.</p> <p>--Resident #49</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--03/30/25 Losartan Potassium 100mg by mouth daily--ordered for 10:00 AM; given at 11:40 AM. This is one hour and 40 minutes late.</p> <p>--03/30/25 Metoprolol Succinate 100mg by mouth daily--ordered for 10:00 AM; given at 11:40 AM. This is one hour and 40 minutes late. I</p> <p>--03/30/25 Farxiga 10mg by mouth daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>--03/30/25 Spironolactone 25mg by mouth daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>--03/30/25 Apixaban 5mg by mouth two times daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>--03/30/25 Divalproex 500mg by mouth two times daily--ordered for 10:00 AM; given at 11:39 AM. This is one hour and 39 minutes late.</p> <p>--Resident #37</p> <p>--03/30/25 Duloxetine 20mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Farxiga 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Amlodipine Besylate 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Folic Acid 1mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Quetiapine Fumarate 25mg 1/2 tablet by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>--03/30/25 Magnesium Oxide 400mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Potassium Chloride 10meq (milliequivalent) by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>--03/30/25 Lisinopril 10mg by mouth daily--ordered for 8:00 AM; given at 9:54 AM. This is one hour and 54 minutes late.</p> <p>--03/30/25 Senna 8.6mg by mouth twice daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Thiamine 100mg by mouth daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Metoprolol Tartrate 50mg by mouth twice daily--ordered for 8:00 AM; given at 9:55 AM. This is one hour and 55 minutes late.</p> <p>-03/30/25 Basaglar 75 units subcutaneous daily--ordered for 8:00 AM; given at 9:56 AM. This is one hour and 56 minutes late.</p> <p>--Resident #23</p> <p>-03/29/25 Enteral feed Jevity 1.5 calories 474 ml three times daily--ordered for 5:00 PM; given at 7:10 PM. This is 2 hours and 10 minutes late.</p> <p>--Resident #36</p> <p>-Tylenol Extra Strength 500mg give 2 tablets by mouth twice daily--ordered for 10:00 AM; given at 11:47 AM. This is one hour and 47 minutes late.</p> <p>-Glycolax Powder give 17 grams by mouth daily--ordered for 10:00 AM; given at 11:47 AM. This is one hour and 47 minutes late.</p> <p>--Resident #8</p> <p>-Protonix 40mg by mouth twice daily--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>-Escitalopram 5mg by mouth daily--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>-Tylenol Extra Strength 500mg by mouth three times a day--ordered for 9:00 AM; given at 10:52 AM. This is one hour and 52 minutes late.</p> <p>--Resident #7</p> <p>-03/29/25 Sertraline 25mg by mouth daily--ordered for 9:00 AM; given at 10:57 AM. This is one hour and 57 minutes late.</p> <p>--Resident #41</p> <p>-03/30/25 Cymbalta 20mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Zinc 220mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Colace 100mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Metformin 1000mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Protonix 40mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Synthroid 100mcg (microgram) by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Farxiga 10mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Eliquis 5mg by mouth twice daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Sitagliptin 25mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Furosemide 40mg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>-03/30/25 Digoxin 125mcg by mouth daily--ordered for 8:00 AM; given at 9:58 AM. This is one hour and 58 minutes late.</p> <p>--Resident #50</p> <p>-03/29/25 Tylenol Extra Strength 500mg give 2 tablets twice daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Protonix 40mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Aspirin 81mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Omeprazole 20mg twice daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>-03/29/25 Buspar 10mg daily--ordered for 9:00 AM; given at 11:09 AM. This is two hours and 9 minutes late.</p> <p>The following physician's orders for resident treatments were not followed:</p> <p>--Resident #9</p> <p>-03/29/25 apply antifungal to bilateral groin areas twice daily--no documentation for day shift</p> <p>-03/30/25 apply antifungal to bilateral groin areas twice daily--no documentation for day shift</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--03/29/25 cleanse MASD to left buttock with no-rinse foaming wash and pat dry. Apply calazime cream to open areas only. Apply hydroguard to surrounding skin every day and night shift --no documentation for day shift</p> <p>--03/30/25 cleanse MASD to left buttock with no-rinse foaming wash and pat dry. Apply calazime cream to open areas only. Apply hydroguard to surrounding skin every day and night shift --no documentation for day shift</p> <p>--Resident #41</p> <p>-03/29/25 Eye scrubs: mix baby shampoo with warm water, gently wipe each eye separately, rinse with warm water and pat dry, using clean technique every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Eye scrubs: mix baby shampoo with warm water, gently wipe each eye separately, rinse with warm water and pat dry, using clean technique every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Cleanse ulcer to right lower extremity with normal saline, pat dry, apply collagen particles, cover with hydrogel impregnated gauze, wrap with kerlix, and secure with ace wrap every Tuesday, Thursday and Saturday--no documentation for day shift.</p> <p>--Resident #50</p> <p>-03/29/25 Cleanse bilateral buttocks and scrotum with warm water and mild soap, rinse and dry completely. Apply barrier cream after episodes of incontinence--no documentation for day shift.</p> <p>-03/30/25 Cleanse bilateral buttocks and scrotum with warm water and mild soap, rinse and dry completely. Apply barrier cream after episodes of incontinence--no documentation for day shift.</p> <p>-03/29/25 Hydrocortisone External Cream 2.5% Apply to face, back and thighs every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Hydrocortisone External Cream 2.5% Apply to face, back and thighs every day and night shift--no documentation for day shift.</p> <p>--Resident #20</p> <p>-03/29/25 Apply Ammonium Lactate External cream to bilateral lower legs every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Apply Ammonium Lactate External cream to bilateral lower legs every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Silver Sulfadiazine cream 1% apply to bilateral groin and buttocks every day and night shift--no documentation for day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Silver Sulfadiazine cream 1% apply to bilateral groin and buttocks every day and night shift--no documentation for day shift.</p> <p>--Resident #63</p> <p>-03/29/25 Apply barrier cream to MASD to sacrum every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Apply barrier cream to MASD to sacrum every day and night shift--no documentation for day shift.</p> <p>-03/29/25 Cleanse surgical incision to right shoulder with wound cleanser, pat dry, cover with dry dressing every day and night shift--no documentation for day shift.</p> <p>-03/30/25 Cleanse surgical incision to right shoulder with wound cleanser, pat dry, cover with dry dressing every day and night shift--no documentation for day shift.</p> <p>--Resident #42</p> <p>-03/29/25 Cleanse right heel DTI with normal saline, pat dry, apply betadine to area and cover with foam dressing. Secure with kerlix and tape every Tuesday, Thursday and Saturday--no documentation for day shift.</p> <p>--Resident #58</p> <p>-03/29/25 Apply kerlix and coban starting behind the toes up to below the knee on bilateral lower extremities every 3 days per Vascular Surgery--no documentation for day shift.</p> <p>--Resident #61</p> <p>-03/29/25 Enteral Feed: Cleanse site daily with soap and water every day shift--no documentation for day shift.</p> <p>-03/30/25 Enteral Feed: Cleanse site daily with soap and water every day shift--no documentation for day shift.</p> <p>-03/29/25 Monitor surgical incision to right rear head for possible signs/symptoms of infection every day and night shift-no documentation for day shift.</p> <p>-03/30/25 Monitor surgical incision to right rear head for possible signs/symptoms of infection every day and night shift-no documentation for day shift.</p> <p>--Resident #23</p> <p>-03/29/25 Cleanse PEG site with normal saline moistened gauze and pat dry, apply bacitracin and a split gauze and secure with tape every day shift--no documentation for day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Cleanse PEG site with normal saline moistened gauze and pat dry, apply bacitracin and a split gauze and secure with tape every day shift--no documentation for day shift.</p> <p>--Resident #10</p> <p>-03/29/25 Acetic Acid Irrigation Solution 0.25% use 30 cc (cubic centimeters) via irrigation every day and night shift for occlusion--no documentation for day shift.</p> <p>-03/30/25 Acetic Acid Irrigation Solution 0.25% use 30 cc (cubic centimeters) via irrigation every day and night shift for occlusion--no documentation for day shift.</p> <p>-03/29/25 Apply z-guard to buttocks every day and night shift for MASD--no documentation for day shift.</p> <p>-03/30/25 Apply z-guard to buttocks every day and night shift for MASD--no documentation for day shift.</p> <p>--Resident #15</p> <p>-03/29/25 Apply skin prep daily to arterial ulcers to 1st, 2nd and 3rd digits. Notify provider if any signs/symptoms of infection every day shift--no documentation for day shift.</p> <p>-03/30/25 Apply skin prep daily to arterial ulcers to 1st, 2nd and 3rd digits. Notify provider if any signs/symptoms of infection every day shift--no documentation for day shift.</p> <p>--Resident #17</p> <p>-03/29/25 Monitor left foot for any skin changes related to incident where foot was ran over with a wheel chair x one week. Notify physician if any changes occur every day shift--no documentation for day shift.</p> <p>-03/30/25 Monitor left foot for any skin changes related to incident where foot was ran over with a wheel chair x one week. Notify physician if any changes occur every day shift--no documentation for day shift.</p> <p>--Resident #267</p> <p>-03/29/25 Apply skin prep outer great left toe every day shift DTI--no documentation for day shift.</p> <p>-03/30/25 Apply skin prep outer great left toe every day shift DTI--no documentation for day shift.</p> <p>--Resident #268</p> <p>-03/29/25 Monitor surgical incision to left hip, Report any signs/symptoms of infection to provider. Cleanse area with wound cleanser, Pat dry. May leave open to air if no drainage every day and night shift--no documentation for day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-03/30/25 Monitor surgical incision to left hip, Report any signs/symptoms of infection to provider. Cleanse area with wound cleanser, Pat dry. May leave open to air if no drainage every day and night shift--no documentation for day shift.</p> <p>On 04/03/25 at 3:30 PM, the DON confirmed the physician's orders were not followed for medication administration or treatments were completed. The DON stated, I don't know what happened those days .I was out-of-town.</p> <p>failed to provide sufficient staffing for the B hall.</p> <p>ASC PS & all findings</p> <p>FACILITY</p> <p>Sufficient and Competent Nurse Staffing</p> <p>04/03/25 09:18 AM</p> <p>The daily staff posting is hanging at the nurses station.</p> <p>Review of NHPPD</p> <p>05/27/24 2.89</p> <p>07/06/24 2.71</p> <p>08/19/24 2.80</p> <p>09/03/24 3.31</p> <p>11/01/24 2.84</p> <p>11/29/24 2.91</p> <p>12/26/24 2.65</p> <p>RN punches</p> <p>12/14/24 [NAME] Young 12.78</p> <p>06/09/24 [NAME] 12.35</p> <p>06/09/24 [NAME] 12.28</p> <p>07/06/24 [NAME] Young 13.30</p> <p>08/18/24 [NAME] Young 13.12</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>09/02/24 [NAME] 12.00</p> <p>10/31/24 [NAME] 8.00</p> <p>11/29/24 [NAME] 13.00</p> <p>Annual evaluation/Staff Education & Competencies</p> <p>Brooke [NAME] 12/14/24---04/24/24</p> <p>[NAME] 07/28/24---04/24/24</p> <p>Reydhenn Maylig 12/14/24---04/24/24</p> <p>[NAME] 01/11/25---04/22/24</p> <p>[NAME] 09/05/24---04/22/24</p> <p>Interviews with staff</p> <p>04/03/25 9:50 AM RN #26 we are mandated if needed---I haven't been mandated for a couple of months .no I don't feel like I have enough time .I do my treatments and charting in the evening (12 hour shifts). I'm supposed to get a new nurse who will take another med cart .she starts next week yes we have agency. Last weekend we didn't get coverage for a call in .I had 42 residents.</p> <p>04/03/25 10:05 AM NA #41 we have mandation days .we take turns too .in the last month I've gotten mandated 2 times .no I feel I have to rush with care so the little things have to wait like straightening up their rooms and nail care .I work 12 hour shifts 3xs a week.</p> <p>Interview with DON</p> <p>04/03/25 10: for staffing if there are shifts that need covered we use team reach (mass texting system) then we use mandation--per union rules it starts with the people with less seniority then they go to the bottom of the list and we just go down the list. If we still can't get it covered then we have on-call unit managers and ADONs who can cover .we all walk the halls to answer call lights. CNA ratio is 1:10 residents.</p> <p>Daily staffing postings were reviewed for 03/29/25 and 03/20/25. There were two (2) nurses scheduled; one on the red hall and one on the blue hall. The red hall has 26 beds and the blue hall has 42 residents who reside on the blue hall. One nurse had 42 residents. No other nurse was scheduled on the blue hall during day shift.</p> <p>Both of the days, 03/29/25 and 03/30/25, had multiple late medications administered. The treatments were reviewed for both days and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>51553</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, staff interview and record review, the facility failed to ensure daily menus were followed. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 65.</p> <p>Findings included:</p> <p>a) The facility's menu for 03/31/25 was BBQ Pork on Roll, Gelatin Cubes with Whipped Topping and Potato Chips. The BBQ was served on white sandwich bread in the Dining Room and on the hallways per states surveyors' observations. Resident #10, #56 and #26 were on regular diets and all three residents received light bread in place of a roll. Resident #26 demonstrated difficulty picking up and eating the BBQ on light bread. On 04/01/25 at 12:00 PM, the Corporate Dietary Manager #83 confirmed there were no buns/rolls served for the BBQ yesterday. The Corporate Dietary Manager #83 stated, No, we did not. and that the bread truck ran this date.</p> <p>b) The facility's menu for 04/01/25 was Breaded Fish Filet on Roll, Tartar Sauce, Lettuce and Tomato Garnish, Sliced Peaches and Seasoned Potato Wedges. Lettuce and tomato garnish was not served due to serving temperatures.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>51553</p> <p>Based on record review, staff interview, resident interview and observation, the facility failed to prepare and serve food at a safe and appetizing temperature. This failed practice had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 65.</p> <p>Findings included:</p> <p>a) The facility's policy and procedure stated, All foods will be held at appropriate temperatures, greater than 135 (degrees) F (or as state regulation requires) for hot holding, and less than 41(degrees) F for cold food holding.</p> <p>b) On 04/01/25 at 12:00 PM, the food holding temperature were taken by the Corporate Dietary Manager #83. The following temperatures were obtained:</p> <p>-Holding Temperatures for lunch meal:</p> <p>Lettuce 51.8 - put in freezer</p> <p>Shredded Lettuce 50 - put in freezer</p> <p>Fish - 164.2</p> <p>Potato Wedges - 183.7</p> <p>Ground Fish - 181.5</p> <p>Advanced Mechanical Soft potato wedges - 191.1 (skin off)</p> <p>Meatballs - 195.2</p> <p>Pureed peaches - 40.3</p> <p>Rice - 184.2</p> <p>Pureed rice - 182.1</p> <p>Pureed fish - 194.7</p> <p>Peaches - 40.9</p> <p>Cottage cheese - 39.4</p> <p>Pureed rice - 172.4</p> <p>Pureed bread - 170</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Fortified pudding - 39.4</p> <p>The regular leaf lettuce, shredded lettuce and tomatoes were placed in the refrigerator to cool. Final temperatures at 12:16 PM were:</p> <p>Lettuce - 49.4</p> <p>Shredded lettuce - 45.2</p> <p>Tomatoes - 52.9</p> <p>The Corporate Dietary Manager #83 asked the state surveyor, Do you want us to serve? referring to the lettuce and tomato. The state surveyor responded by saying they couldn't tell him to serve or not to serve. Lettuce and tomatoes were not served. No substitution was given for vegetable.</p> <p>c) On 04/01/25 at 12:55 PM, a temperature test tray was taken to B/Blue Wing to check the temperature. Temperatures were taken and confirmed by Corporate Dietary Manager #83. Temperatures were as follows:</p> <p>Fish sandwich - 127.7</p> <p>Potato wedges - 113.1</p> <p>Peaches - 96.6</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51553</p> <p>Based on observation, staff interview and record review, the facility failed to ensure food was stored properly and food preparation equipment was clean. This failed practice had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 65.</p> <p>Findings included:</p> <p>a) The facility's policy and procedure stated, All foods are labeled and dated with the name of the product and the date received and use by date once opened. Manufacturer use by dates are used unit opened. Prepared foods are labeled and dated with the name of product, date opened, and use by date.</p> <p>b) On 03/31/25 at 11:25 PM, the Kitchen Investigation was initiated with the Corporate Dietary Manager #83. The following items were observed and confirmed:</p> <p>Frozen chicken breast in an opened ziploc with no dates on the package.</p> <p>Imperial Beef Base was opened and not dated.</p> <p>Celery and Lettuce were opened, uncovered in a box and not dated.</p> <p>Sandwich bread was opened and not dated.</p> <p>The Corporate Dietary Manager #83 asked, Do we need a use by date?</p> <p>c) On 04/01/25 at 10:40 AM, the pantry on the Memory Unit contained an opened can of Dr. Pepper with tape over opening. An open date only was written on the can and no use by date. The finding was confirmed by Memory Support Director #52. She stated, I will get rid of that ASAP.</p> <p>d) On 04/01/25 at 04/01/25 11:55 AM, the pantry on C hall contained a resident's sherbet opened and not dated, Hormel Thick and Easy - Honey Thick water opened with no date range/use by date, and resident's snacks (fortified pudding and applesauce) with no date range/use by date. These findings were confirmed by Licensed Practical Nurse(LPN) #11.</p> <p>e) The sink behind the dining room serving center for handwashing had a brown substance in the sink bowl and no trash can to dispose of paper towels/garbage. The Corporate Dietary Manager #83 stated, We don't serve here. Dried food on the outside of the refrigerator in the kitchen was confirmed by the manager.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>51553</p> <p>Based on staff interview and observation, the facility to ensure garbage was disposed of properly. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 65.</p> <p>Findings included:</p> <p>a) Dumpsters</p> <p>On 04/01/25 at 9:55 AM, two dumpsters located behind a wooden fence were observed by a state surveyor. Gloves and food as well as cup lids, straws, plastic forks, and boxes laying around both dumpsters. were found. On garbage dumpster #1 both lids were open with lids laid back. Garbage dumpster #2 was open with the lid broken off.</p> <p>On 04/01/25 at 10:00 AM, the Administrator was notified and the state of the dumpsters were confirmed. The Facility Administrator stated, I see what you are saying. Usually the dumpsters are replaced yearly. We will have to call the company and get a new dumpster. Let me call (Name of the Director of Nursing) and let her know. She is my go to person.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to maintain complete, accurate, and timely medical records. This deficient practice had the potential to affect five (5) of 22 residents reviewed in the long-term care survey sample. Resident Identifiers: #5, #58, #25, #51, and #3. Facility census: 65.</p> <p>Findings included:</p> <p>a) Resident #5</p> <p>On 04/01/25 at 8:48 AM, Licensed Practical Nurse (LPN) #11 was observed administering morning medications to Resident #5. One of the medications administered to the resident was Zyrtec (cetirizine hydrochloride) 10 mg.</p> <p>Review of Resident #11's physicians' orders showed on 03/29/25 the resident was ordered Zyrtec allergy oral tablet (Cetirizine HCl [hydrochloride], give 1 tablet by mouth one time a day for sinusitis. The order did not specify the dosage for the medication.</p> <p>On 04/01/25 at 9:50 AM, the Director of Nursing confirmed Resident #5's Zyrtec didn't have a dosage ordered. She stated the pharmacy only supplies one dosage of Zyrtec to the facility. She stated she would have the order revised to include the dosage.</p> <p>According to the Zyrtec (Cetirizine hydrochloride) packaging insert available on-line on the Food and Drug Administration Website, the medication comes in 10 milligrams (mg) and 5 mg tablets, as well as syrup.</p> <p>No further information was provided through the completion of the survey process.</p> <p>b) Resident #58</p> <p>On 03/31/25 at 4:00 PM, the Physician Orders for Scope of Treatment (POST) form for Resident #58 was reviewed. The review found the resident's signature was not dated when completed.</p> <p>On 04/01/25 at 9:30 AM, the Director of Nursing (DON) confirmed the resident's signature was not dated. The DON stated, I saw that.</p> <p>c) Resident # 25</p> <p>On 04/03/25 at 9:52 AM a review of the medical record for Resident #25 who was admitted on [DATE] with diagnoses of schizoaffective disorder, depressive type, anxiety disorder, major depressive disorder, vascular dementia with agitation, psychotic disorder, seizures and mood disturbance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08//28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25/21/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/08/25 for night shift</p> <p>03/12/25 for day shift</p> <p>03/15/25 for night shift</p> <p>03/17/25 for day shift</p> <p>In an interview on 04/03/25 at 8:40 AM with the Administrator, he concurred there were issues with documentation and care plans.</p> <p>d) Resident #51</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/25 at 9:58 AM a review of the medical record for Resident #51 who was admitted on [DATE] with diagnoses of depression, Alzheimer's, dementia with behavioral disorder and wandering.</p> <p>A review of the care plan found the following:</p> <p>Focus is at risk for complications related to the use of antipsychotic, and antidepressant medications dated created 08/17/23 with revision on 11/23/24.</p> <p>Goal will have the smallest most effective dose without side effects through to next review. Date initiated 08//28/23 and revision date of 04/02/25.</p> <p>Interventions administer medications as ordered, be alert for side effects of antidepressants including: sedation, dry mouth . Initiated 08/14/24 revised on 08/15/24.</p> <p>-Be alert for side effects of antipsychotic medication including: blurred vision, sedation, dry mouth . Initiated 08/14/24 revised 08/15/24.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. pacing, 2. emotional outbursts. 3. verbal aggression every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>A review of the Medication Administration Record (MAR) found a physicians order on 01/13/25 to Monitor for behaviors: 1. refusal of care, 2. physical aggression toward staff. 3. delusions every day and night shift. Document number (#) of behaviors if none then 0.</p> <p>The January 2025 MAR had no evidence of monitoring behaviors on the following shifts:</p> <p>01/14-16/25 day shift and night shift.</p> <p>01/17/25 for night shift</p> <p>01/28/28 for night shift</p> <p>The February 2025 MAR had no evidence of monitoring behaviors on day shift on 02/11-12/25.</p> <p>The March 2025 MAR found no evidence of behavior monitoring on the following:</p> <p>03/09/25 for night shift</p> <p>03/12/25 for day shift</p> <p>03/15/25 for night shift</p> <p>03/17/25 for day shift</p> <p>In an interview on 04/03/25 at 8:40 AM with the Administrator, he concurred there were issues with documentation and care plans.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e) Resident #3</p> <p>The facility failed to ensure therapy documentation was completed timely for Resident #3. The facility's policy and procedure for Charting was reviewed. The policy stated, 4. Standardly, documentation is completed on the day of service, preferably at the time of service. 4.1 For extenuating circumstances, clinical documentation is completed and included in the medical record no later than seven days after service, and/or consistent with site of service policy, as per the most restrictive timeframe. Resident #3's speech therapy documentation was reviewed. Documentation reviewed included:</p> <p>Speech Therapy Evaluation completed on 2/21/25 - signed 2/25/25.</p> <p>Speech Therapy Progress Report due 3/7/25 - signed 3/11/25.</p> <p>Speech Therapy Recertification due 3/23/35 - signed 3/26/25.</p> <p>Speech Therapy Daily Notes:</p> <p>Date of Service: 3/27/25 Completion Date: 3/31/25</p> <p>Date of Service: 3/26/25 Completion Date: 3/31/25</p> <p>Date of Service: 3/25/25 Completion Date: 4/1/25</p> <p>Date of Service: 3/24/25 Completion Date: 4/1/25</p> <p>Date of Service: 3/21/25 Completion Date: 3/25/25</p> <p>Date of Service: 3/20/25 Completion Date: 3/24/25</p> <p>Date of Service: 3/19/25 Completion Date: 3/24/25</p> <p>Date of Service: 3/16/25 Completion Date: 3/19/25</p> <p>Date of Service: 3/14/25 Completion Date: 3/16/25</p> <p>Date of Service: 3/13/25 Completion Date: 3/16/25</p> <p>Date of Service: 3/12/25 Completion Date: 3/16/25</p> <p>Date of Service: 3/11/25 Completion Date: 3/16/25</p> <p>Date of Service: 3/10/25 Completion Date: 3/16/25</p> <p>Date of Service: 3/7/25 Completion Date: 3/11/25</p> <p>Date of Service: 3/6/25 Completion Date: 3/10/25</p> <p>Date of Service: 3/5/25 Completion Date: 3/10/25</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Date of Service: 3/4/25 Completion Date: 3/4/25</p> <p>Date of Service: 3/3/25 Completion Date: 3/7/25</p> <p>Date of Service: 2/27/25 Completion Date: 3/3/25</p> <p>Date of Service: 2/26/25 Completion Date: 3/2/25</p> <p>Date of Service: 2/25/25 Completion Date: 3/2/25</p> <p>Date of Service: 2/24/25 Completion Date: 2/27/25</p> <p>Date of Service: 2/21/25 Completion Date: 2/24/25</p> <p>On 04/02/24 at 04:40 PM, the Speech Therapist confirmed her documentation is sometimes late. The Speech Therapist reported, she reviews her notes she has written during the therapy session with the resident to complete her documentation electronically at a later time/date. The Speech Therapist reported Net Health goes down frequently and there are parts of the building where internet connection unavailable at times. The Speech Therapist stated, The timeliness is on me.</p> <p>45173</p> <p>51553</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>45173</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and staff interview, the facility failed to ensure required members of the Quality Assurance and Performance Improvement (QAPI) team were present to hold the required quarterly meeting. Facility Census: 65.</p> <p>a) QAPI members</p> <p>On 04/03/25 at 1:10 PM, a review of the sign in sheets for QAPI was completed. The review found the Director of Nursing (DON) position was empty during the dates of 02/19/24 through 04/08/24. There was no one filling in the DON position. Therefore, for the dates of 02/19/24 through 04/08/24, the required members did not attend.</p> <p>On 04/03/25 at 2:30 PM, this time frame was confirmed by the Administrator and the current DON.</p> <p>b) QAPI meetings</p> <p>On 04/03/25 at 2:40 PM, a review of the sign in sheets for QAPI was completed. The review found there were no meetings held in the months of 01/2025, 02/2025 or 03/2025.</p> <p>On 04/03/25 at 3:00 PM, the Administrator confirmed there were no meetings held in 01/2025, 02/2025 or 03/2025.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>30153</p> <p>Based on observation, record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. These were random opportunities for discovery that had the potential to affect more than a limited number of residents. The facility failed to ensure Enhanced Barrier Precautions (EBP) signage was appropriately placed outside Resident #3's room. The facility failed to follow EBP for Resident #7. The facility also failed to provide resident hand hygiene in the dining room. Resident Identifiers: #3 and #7. Facility census: 65.</p> <p>Findings included:</p> <p>a) Resident #3</p> <p>The facility's policy titled Enhanced Barrier Precautions, with effective date 01/06/20 and revision date 12/16/24, stated Enhanced Barrier Precautions (EBP) would be implemented for residents with wounds or indwelling medical devices.</p> <p>On 04/01/25 at 8:43 AM, Licensed Practical Nurse (LPN #11) stated where the EBP signage is placed outside the residents' room notifies staff which resident in that room required EBP. A sign above the resident name plates indicates the resident in Bed A required EBP. A sign below the resident name plates indicates the resident in bed B require EBP. A sign beside the name plates indicates both residents in the room require EBP.</p> <p>Review of Resident #3's physician's orders showed the resident had an order written on 03/27/25 for Infection precautions - enhanced barrier. The resident had an indwelling urinary catheter and a pressure ulcer dressing.</p> <p>During an observation on 04/01/25 at 12:55 PM, Resident #3 was noted to be in bed B. The EBP outside her door was above the name plates, indicating her roommate, Resident #268, required EBP.</p> <p>On 04/01/25 at 2:36 PM, the Director of Nursing stated both Resident #3 and Resident #268 required EBP. She confirmed the sign should have been beside the name plates to indicate both residents required</p> <p>b) Hand hygiene</p> <p>The facility failed to provide a safe and sanitary dining environment by not providing resident hand hygiene before meals. The facility's policy and procedure for Patient Hand Hygiene stated, Educate the patient and their representative on performing hand hygiene after toileting and before meals. On 03/31/25 at 12:55 PM during the dining room observation, no hand hygiene was observed being performed for any residents eating in the facility's main dining room. Resident #13 began eating his lunch which included a sandwich. The state surveyor intervened and asked the Recreation Director if the residents usually have hand hygiene completed prior to meals. The Recreation Director stated, We should be doing that. The Social Services Director went out of the dining room to go get hand sanitizer packets.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c) Resident #7</p> <p>On 04/02/25 at 3:31 PM an observation of a decubitus dressing change on Resident #7 with Registered Nurse (RN) #69 found RN #69 did not wear Personal Protection Equipment (PPE- gown) during the dressing change and then during incontinence brief change. RN #69 doubled checked the Enhanced Barrier Precautions (EBP) sign outside the door and stated that both residents are on EBP and she should have worn a gown and not just gloves.</p> <p>39043</p> <p>51553</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Sistersville Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Wood Street Sistersville, WV 26175	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to provide pneumococcal immunizations according to standards of practice. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of immunizations. Resident identifier: #59. Facility census: 65.</p> <p>Findings included:</p> <p>a) Resident #59</p> <p>Review of the facility's policy titled, Pneumococcal Vaccination, with effective date 05/04/15 and revision date 09/13/24, gave the following instructions:</p> <ul style="list-style-type: none"> - Obtain patient/representative consent for pneumococcal vaccination - Administer the vaccine <p>Review of Resident #59's electronic health records showed the resident's Medical Power of Attorney (MPOA) consented on 10/28/24 for the resident to receive the pneumococcal vaccination. Resident #59's Medication Administration Records (MARs) for October and November 2024 contained no documentation the resident received pneumococcal vaccination.</p> <p>On 04/02/25 at 1:55 PM, the Director of Nursing (DON) confirmed the facility had no documentation Resident #59 had received pneumococcal vaccination after her MPOA consented for the vaccination.</p>